

**DENTAL FACILITY DESIGNATION WORKSHEET**

Facility Name: \_\_\_\_\_ Clinics at Facility: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

County: \_\_\_\_\_ HPSA Facility Serves (Name/ID): \_\_\_\_\_

Facility is public or non-profit: ☐ Yes ☐ No\*

☐ Metropolitan

☐ Non-metropolitan

☐ Frontier

**1) Provision of Services (one):**

☐ More than 50% of facility's dental care services are being provided to residents of a HPSA.

☐ Within 40 minutes of HPSA and facility is accessible to residents of HPSA (i.e., no socioeconomic differences).

To: _____		
Distance by: <input type="checkbox"/> Auto <input type="checkbox"/> Bus <input type="checkbox"/> Other		
Source:		
<input type="checkbox"/> Rand McNally Atlas		
<input type="checkbox"/> Maps-on-us		
<input type="checkbox"/> Other:		
Road Type:	Miles	Minutes
Interstate 1.33		
Primary 1.6		
Secondary 2.0		
Total		

**2) Insufficient Capacity (one):**

☐ (i)  $\geq 5000$  visits per year per FTE dentist.

\_\_\_\_\_ Number of visits \_\_\_\_\_ FTE \_\_\_\_\_ Visits/FTE

☐ (ii)  $\geq 6$  week waits for appointments for routine dental services.

\_\_\_\_\_ Weeks

☐ (iii) 2/3 or more dentists in area do not accept new patients.

\*Reject application if not a community health center, public or non-profit facility.

**DENTAL FACILITY DESIGNATION WORKSHEET****Applicant Reminders:**

- ☐ Map with boundary of HPSA, location of facility, and route from HPSA population center to facility.
- ☐ FTE Spreadsheet, if applicable

**Applicant Requests:**

- ☐ Designate   ☐ Continue   ☐ Reinstate

**Rational:**

- ☐ Meets criteria                      ☐ Other

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

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